“It is important for us to meet the needs of our beneficiaries, and making sure we communicate with them clearly is a top priority. The site redesign saves time and gives beneficiaries up-to-date information.” -- Army Maj. Gen. Elder Granger, deputy director, TRICARE Management Activity, commenting on TRICARE’s Web site redesign.
Congressional Schedule

Sen. Tom Coburn (R-OK.), a practicing physician and ranking member of an oversight subcommittee, issued a 115-page minority office report questioning the CDC’s spending on projects that include an employee fitness center with $200,000 in equipment such as zero-gravity chairs and a mood-enhancing light show, and a $1.7 million effort to have accurate medical information portrayed in movies and TV shows. The report, *CDC Off Center*, examines how the CDC has spent its $10 billion budget and investigates wasteful spending. The CDC is responsible for treating and preventing diseases and dealing with public safety threats, including the threat of bioterrorism.

According to the report, the CDC has spent millions and even billions of dollars to help prevent certain diseases, such as HIV, among Americans with little result. In the case of HIV, despite spending billions of dollars, CDC cannot even report how many Americans have the communicable disease.

Some examples in the report of CDC’s spending:

- $1.7 million — including terrorism funds — on a [Hollywood liaison program](#), which happens to be run by a former employee
- $45 million for conferences, including those featuring prostitutes, protests, and beach parties
- $30,000 employee saunas in a [new $200,000 fitness center](#) that also includes mood-enhancing lightshows and $3,500 worth of zero-gravity chairs
- Syphilis prevention funds used to feature a porn star’s presentation
- HIV/AIDS prevention funds spent on a transgender beauty pageant
- $250,000 spent so two former employees could help build staff morale
- $335 million on ads to fight childhood obesity
- $128,000 in [CDC bioterrorism funds spent by L.A. County](#) on trinkets such as letter openers, whistles, magnets, mouse pads, flashlights, pens, and travel toothbrushes

This report is part of a series of oversight reports on federal agencies. Senator Coburn’s hope is that more and better oversight will assist federal agencies and those in Congress with responsibility for overseeing agency budgets, with reigning in wasteful spending; demanding measurable results from programs and grantees; and with reevaluating current spending before asking politicians and
taxpayers to send more scarce tax dollars.

• On June 12, 2007, the White House announced that President Bush intends to appoint Bonnie McElveen-Hunter, of North Carolina, to be Chairman of the Board of Governors of the American National Red Cross, for a term of three years.

Military Health Care News

• The Office of the Secretary of Defense for Health Affairs, TRICARE Management Activity, published a notice in the *Federal Register* on June 13, 2007, to announce a Military Health System (MHS) demonstration project called *Disease Management (DM) Demonstration Project* for TRICARE Standard Beneficiaries. TRICARE currently requires the Managed Care Support Contractors (MCSCs) to provide disease management services under the current contracts, without specific guidance. Based upon the current legal statutes authorizing preventive health care services, TRICARE must conduct a demonstration under 10 U.S.C. 1092 in order to offer TRICARE Prime benefits to TRICARE Standard beneficiaries under the DM program already in existence. Under this demonstration, disease management services will be provided to TRICARE Standard beneficiaries as part of the current MHS DM programs. The demonstration project will enable the MHS to provide uniform policies and practices on disease and chronic care management throughout the TRICARE network. Additionally, the demonstration will help determine the effectiveness of DM programs in improving the health status of beneficiaries with targeted chronic diseases or conditions, and any associated cost savings.

• Health Net Federal Services (Health Net), the managed care support contractor for the TRICARE North Region, which provides health care services to over 3 million uniformed services beneficiaries, active and retired, and MHN, Health Net’s behavioral health company, announced the opening of a new behavioral health clinic called, “Mountain Community TRICARE Behavioral Health Clinic,” created in direct response to the increased deployment demands facing the Fort Drum, N.Y., community. Fort Drum is home to the 10th Mountain Division and reserve units, and mobilizes and trains nearly 80,000 troops annually.

The clinic, located on Fort Drum, offers behavioral health care services to address stress, anxiety, grief and marital issues, as well as other services that will enable family members of active duty service members to cope with the challenges that may accompany
serving our nation.

This clinic is specifically targeted to the Fort Drum community’s non-active duty TRICARE beneficiaries. Active duty service members should seek care from Fort Drum MEDDAC (U.S. Army Medical Department Activity) Behavioral Health Services. Service members may be cared for at the clinic if they receive a referral from their primary care manager and authorization from Health Net Federal Services. The clinical operations will be managed by MHN, Inc.  
http://home.businesswire.com/portal/site/google/index.jsp?ndmViewId=news_view&newsId=20070613005202&newsLang=en

• On June 12, 2007, UnitedHealth Group announced the executive leadership for the company’s new division, Military & Veterans Health Services. Retired Navy Reserve Rear Adm. Donald Gintzig has been appointed chief executive officer of the division. Ms. Lori McDougal has been appointed chief operating officer of the division.

Rear Adm. Gintzig will work in partnership with UnitedHealth’s Public and Social Markets group leaders and directly with executives across the enterprise. Gintzig currently serves as Deputy Commander for the United States Navy Medicine East in Portsmouth, VA, which includes a tertiary teaching medical center, 13 hospitals, and over 25 clinics in the eastern half of the U.S. and Europe. He also has served as associate chief, Bureau of Medicine and Surgery, in Washington D.C. As a civilian, Gintzig has more than 25 years of senior health care executive leadership experience in hospitals and health systems. He most recently served as president and chief executive officer of Middle Tennessee Medical Center and Executive Vice President and chief operating officer of Saint Thomas Health Services.

An executive with the company since 1983, Ms. McDougal has held positions of increasing responsibility with broad operational experience both domestically and internationally. Ms. McDougal also served for ten years as UnitedHealth’s program director for a U.S. Department of Defense contract to provide consulting and analysis for the military health care system. Ms. McDougal has helped establish the business development process and set the stage for future growth opportunities for this new division.

UnitedHealth Group’s Military & Veterans Health Services will focus the company’s experience, resources and innovative technology on working with the current military systems to complement and improve the quality of health care and medical outcomes for the nation’s military personnel and veterans; and help reduce administrative costs to enhance the long-term success of the health care programs on which these men and women
The Department of Defense announced that Navy Rear Adm. (lower half) Christine M. Bruzek-Kohler has been nominated for appointment to the grade of rear admiral. Bruzek-Kohler is currently serving as chief of staff, program executive officer, N-09, Bureau of Medicine and Surgery (BUMED) and director of the Nurse Corps, Washington, D.C.

According to the AP/Daily Star, about one-third of the 9.1 million people covered under the TRICARE military health care system seek mental health counseling in their first year after returning from war. In addition, the publication reports that soldiers returning from war are finding it more difficult to get mental health treatment because military insurance is cutting payments to therapists, on top of already low reimbursement rates and a tangle of red tape.

Wait lists now extend for months to see a military doctor and it can takes weeks to find a private therapist willing to take on members of the military. The challenge appears greater in rural areas, where many National Guard and Reserve troops and their families live.

The Department of Defense's (DoD's) Mental Health Task Force found that TRICARE's psychological health benefit is hindered by fragmented rules and policies, inadequate oversight and insufficient reimbursement. In addition, the task force heard testimony from representatives from Fort Campbell, Ky., and Fort Bragg, N.C. — Army posts with heavy war deployments — that they routinely field complaints about the difficulty in locating mental health specialists who accept TRICARE. TRICARE's reimbursement rate is tied to Medicare's, which pays less than civilian employer insurance. The rate for mental health care services fell by 6.4 percent this year as part of an adjustment in reimbursements to certain specialties.

According to the DoD, TRICARE has sped up payments to encourage more doctors to participate and in some locations, such as Idaho and Alaska, has raised rates to attract physicians.

Data from TRICARE’s Medical Benefits and Reimbursement System office shows that TRICARE pays mental health providers as much or more than a corporate plan would pay a therapist for treating a patient — although in some cases it is lower. There are different coverage plans within TRICARE and the amount paid to providers varies by plan, location, specialty and services performed.
Active duty troops use TRICARE Prime, a managed-care option maintained by private contractors. Their mental health care is free. Guard and Reserve troops and their families frequently use TRICARE Standard, a fee-for-service plan. They pay an annual deductible and 20 percent of the amount TRICARE pays the therapist.

In a limited study by TRICARE released earlier this year, about two out of three civilian psychiatrists in 20 states were willing to accept TRICARE Standard clients among their new patients, the lowest acceptance rate for any specialty.


Veterans Health Care News

The Department of Veterans Affairs (VA) announced the expansion of its consolidated mail-out pharmacy program during a dedication ceremony on June 11, 2007, adding a new building and improved production system for the Dallas VA Consolidated Mail Outpatient Pharmacy.

VA opened its first mail-out pharmacy in 1994. The seven existing mail-out pharmacies have become valuable partners in VA’s total health care program for veterans. With an annual budget of $3 billion, these pharmacies dispense 75 percent of all VA prescriptions. Consolidated Mail Outpatient Pharmacies will handle nearly 100 million prescriptions this year, a quadrupling of service compared to the 25 million prescriptions dispensed 10 years ago. Most pharmaceuticals are mailed within 48 hours of the mail-out pharmacy receiving the prescription.

VA mail-out pharmacies begin processing pharmaceuticals after downloading electronic prescriptions from VA health care providers. Medicines are mailed directly to patients. VA’s seven consolidated mail-out pharmacies are in Boston; Charleston, S.C.; Chicago; Dallas; Leavenworth, Kan.; Nashville, Tenn., and Tucson,
The Department of Veterans Affairs (VA) announced plans to hire suicide prevention counselors at each of its 153 medical centers. The new suicide prevention counselors will join the 9,000 mental health professionals already employed by VA. The Department spends nearly $3 billion a year for mental health services. About 1 million VA patients have a mental health diagnosis.

VA Secretary Jim Nicholson previously announced that a four-day meeting will be held in Washington DC in July of mental health clinicians and researchers from across the country. This special forum will review all of the Department’s programs to care for the mental health needs of veterans, especially those returning from combat in Iraq and Afghanistan.

Mental health services are provided at each of VA’s 153 medical centers and more than 700 community-based outpatient clinics. Last month, Nicholson announced an initiative to hire 100 new employees to provide readjustment counseling at each of the Department’s 207 community-based Vets Centers. (http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1347)

Health Care News

The Centers for Disease Control and Prevention (CDC) announced on June 12, 2007, that water in the drinking water system for the Tarawa Terrace family housing area at U.S. Marine Corps Base Camp Lejeune, N.C., was contaminated with tetrachloroethylene (PCE), a dry cleaning solvent, during the period November 1957 through February 1987. More than 75,000 residents could have been affected by this contamination.

The analysis conducted by the Agency for Toxic Substances and Disease Registry (ATSDR) determined that PCE may be a carcinogen. But the effects of consumers’ exposure to drinking water contaminated with PCE are not known. Some health studies have found adverse effects in occupational settings. However, exposure to PCE alone typically does not mean a person will experience adverse health effects. Many factors determine whether people experience adverse health effects due to chemical exposure.
The maximum concentration of PCE in Tarawa Terrace drinking water was estimated to be about 200 micrograms per liter. The U.S. Environmental Protection Agency’s (EPA) maximum contaminant level of five micrograms per liter during the period. The contamination occurred because the solvent leaked into the Tarawa Terrace drinking water system from an off-base dry-cleaner. In 1987, the Tarawa Terrace water treatment plant was disconnected from the base’s drinking water supply system because of contamination.

The analysis of the Tarawa Terrace drinking water system is part of ATSDR’s epidemiological study at Camp Lejeune. The study will focus on babies born during the period 1968-1985 up to the time that they were one year old. PCE is in a class of chemicals known as volatile organic compounds, or VOCs. Some scientific literature has associated VOCs with birth defects and childhood cancers, such as spina bifida, anencephaly, cleft lip, cleft palate, leukemia and non-Hodgkin’s lymphoma.

Former Camp Lejeune Marines and their families who resided in family housing at the base are encouraged to get routine physicals and monitor their health for any changes and can find the levels of PCE and PCE degradation by-products in the drinking water serving their homes in Tarawa Terrace by visiting the ATSDR Web site and entering the dates they lived in Tarawa Terrace housing from 1951 to 1987. http://www.cdc.gov/od/oc/media/pressrel/2007/r070612.htm

• HHS Secretary Mike Leavitt announced timelines and key activities necessary to transition the American Health Information Community (AHIC) from a federal advisory committee to an independent, private-sector health Information Technology (IT) leadership entity.

The announcement, made at the 14th meeting of the AHIC, officially launches the transition plan and moves forward the national health IT agenda toward achieving President Bush’s goal for most Americans to have access to secure electronic health records by 2014. As its charter mandates, the AHIC is required to explore the formation of an AHIC successor organization (ASO) in the private sector. The AHIC is expected to advance its recommendations to the Secretary so that the ASO may be in place by January, 2009.

Three contracts to develop potential business models for the future ASO were awarded to Avalere Health LLC, Booz Allen Hamilton and Alchemy LLC earlier this year. Each contract is valued at approximately $100,000. The proposed governance and
business models will be evaluated and used to develop a prototype model of the ASO.

The ASO will be established as a voluntary public-private partnership within the private sector. It will seek to serve as the primary organization in the United States for leading the integration and use of health IT that is standards-based and interoperable while ensuring that health information is protected and portable.

Key activities of the timeline for the AHIC transition to the ASO include:

- **June 2007**: Review and analysis of the three potential ASO models. Evaluation criteria will be developed to identify most viable elements and practices from the three different ASO models;
- **July 2007**: Public comment will be requested from July 2-20, 2007. Public comments will be synthesized and incorporated into next version of the ASO prototype model that will be presented to the AHIC;
- **August/Sept 2007**: Further analysis and AHIC member feedback will be solicited to refine the transition plan;
- **September 2007**: Final prototype and transition plan presented at the September 18, 2007 AHIC meeting;
- **Fall 2007**: New entity formed and begins to operate as the new ASO;
- **Early 2008**: ASO formed with interim Board and meeting schedule announced; and
- **January 2009**: Permanent ASO Board selected.

The National Center for Research Resources (NCRR), a part of the National Institutes of Health (NIH), announced it will provide $20.65 million for 14 High-End Instrumentation (HEI) grants that will fund cutting-edge equipment required to advance biomedical research. Awarded to research institutions around the country, the one-time grants support the purchase of sophisticated instruments costing more than $750,000.

The 14 awards will enable the purchase of a variety of sophisticated instrumentation at institutions nationwide, such as Tesla human magnetic resonance imaging (MRI) and spectroscopy system, which provides the highest magnetic imaging available for humans and confocal imaging system, to enable the study of calcium signaling in living cells, as well as investigations involving neuronal and brain slice imaging.

In order to qualify for a HEI award, institutions must identify three or more NIH-funded investigators whose research requires the requested instrument. Matching funds are not required for these grants, which provide a maximum of $2 million each. However,
institutions are expected to provide an appropriate level of support for associated infrastructure, such as building alterations or renovations, technical personnel, and post-award service contracts for instrument maintenance and operation.

NCRR provides laboratory scientists and clinical researchers with the environments and tools they need to understand, detect, treat, and prevent a wide range of diseases. Central to this effort, NCRR leads the Clinical and Translational Science Award (CTSA) program — a national consortium of academic health centers that will transform the conduct of clinical and translational research to ensure that biomedical discoveries are rapidly translated into prevention strategies and clinical treatments for rare and common diseases.  


• A new research report found that the likelihood a person will manifest clinical signs of dementia in the brain increases with the number of different disease processes present in his or her brain. The research was funded by the National Institute on Aging (NIA), part of the National Institutes of Health, and conducted at the Rush Alzheimer’s Disease Center at Rush University Medical Center in Chicago.

Among their findings is the observation that the combination of Alzheimer’s disease and cerebral infarcts (strokes) is the most common mix of pathologies in the brains of people with dementia. The implication of these findings is that public health efforts to prevent and treat vascular disease could potentially reduce the occurrence of dementia, the researchers say in the paper.

The researchers used data from the Rush Memory and Aging Project — an ongoing study of 1,200 elderly volunteers who have agreed to be evaluated every year and to donate their brains upon death. The current study compared clinical and autopsy data on the first 141 participants who have died.

Comparison of the clinical and autopsy results showed that only 30 percent of people with signs of dementia had Alzheimer’s disease alone. By contrast, 42 percent of the people with dementia had Alzheimer’s disease with infarcts and 16 percent had Alzheimer’s disease with Parkinson’s disease (including two people with all three conditions). Infarcts alone caused another 12 percent of the cases. Also, 80 of the 141 volunteers who died had sufficient Alzheimer’s disease pathology in their brains to fulfill accepted neuropathologic criteria for Alzheimer’s disease, although in life only 47 were clinically diagnosed with probable or possible Alzheimer’s disease.

NIA is conducting clinical trials to determine whether interventions for cardiovascular disease can prevent or slow the progress of Alzheimer’s disease. On-going trials cover a range of interventions such as statin drugs, vitamins and exercise. NIA leads the federal effort supporting and conducting research on aging and the medical, social and behavioral issues of older people, including

• New *State Snapshots* released by the federal Agency for Healthcare Research and Quality (AHRQ) show states have made promising gains in health care quality while identifying needed improvements in areas ranging from cancer screening to treatments of heart attack patients.

AHRQ's *State Snapshots* Web tool was launched in 2005. It is an application that helps state health leaders, researchers, consumers, and others understand the status of health care quality in individual states, including each state's strengths and weaknesses.

The 51 *State Snapshots*—every state plus Washington, D.C.—are based on 129 quality measures, each of which evaluates a different segment of health care performance. While the measures are the products of complex statistical formulas, they are expressed on the Web site as simple, five-color "performance meter" illustrations.

For a subset of 15 "State Rankings for Selected Measures," chosen to represent a broad range of common diseases, the *State Snapshots* highlight specific state strengths. New York, for example, ranks best for its low suicide rate. Montana ranks first for pneumonia vaccinations for seniors. Utah ranks first for its low colorectal cancer death rate. No state is good at everything, however, and the State Snapshots point out areas in which states need improvement.

The data, drawn from AHRQ's 2006 *National Healthcare Quality Report*, come from various data sources that cover multiple years. The statistics provide state-specific information but also underscore the reality that some shortcomings in health care quality are widespread. On average, for example, states reported that only about 59 percent of adult surgery patients insured by Medicare receive appropriate timing of antibiotics.

The State Snapshots provide summaries that measure health care quality in three different contexts: by types of care (such as preventive, acute, or chronic care), by settings of care (such as nursing homes or hospitals), and care by clinical area (such as care for patients with cancer or respiratory diseases). The 129 measures range from preventing bed sores to screening for diabetes-related foot problems to providing antibiotics quickly to hospitalized pneumonia patients. The State Snapshots also allow users to compare a State's performance against other States in the same region, plus how a State compares against "best performing States." [http://www.ahrq.gov/news/press/pr2007/snapshotspr.htm](http://www.ahrq.gov/news/press/pr2007/snapshotspr.htm)
On June 12, 2007, the U.S. Food and Drug Administration (FDA) released a report that concludes there are no significant industrywide problems in the recovery of human tissues used for transplantation. The report was issued by FDA's Human Tissue Task Force (HTTF), an intra-agency group assembled in August 2006 to evaluate the effectiveness of FDA's tissue regulations.

The HTTF recommended targeted inspections or a "blitz" of U.S. companies that recover human tissues – including tendons, ligaments, bone and other musculoskeletal tissues. One goal of the blitz was to look for more widespread problems in tissue recovery after FDA ordered two companies to cease manufacturing in 2006. FDA had found that these companies were not following procedures intended to prevent infectious disease transmission.

Investigators from FDA's Office of Regulatory Affairs (ORA) inspected 153 major human tissue recovery firms from October 2006 through March 2007. While some deviations from the regulations were identified, no major inaccuracies or deficiencies were found that could put tissue recipients at risk.

Based on data from the blitz, HTTF reported that nearly all recovery firms were in substantial compliance with FDA's comprehensive risk-based tissue regulations that went into effect in May 2005.


Approximately nine percent of youths aged 12 to 17, and 7.6 percent of adults aged 18 or older, experienced at least one major depressive episode (MDE) in the past year according to data released today by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The new analysis from SAMHSA’s National Survey on Drug Use and Health (NSDUH) shows that among 12 to 17 year olds, rates of past year MDE were among the highest in Idaho (10.4 percent) and Nevada (10.3 percent). The rates were among the lowest in Louisiana (7.2 percent) and South Dakota (7.4 percent). According to the survey, rates of past year MDE among adults aged 18 or older were among the highest in Utah (10.1 percent) and Rhode Island (9.9 percent). Hawaii and New Jersey had rates among the lowest (6.7 percent and 6.8 percent respectively).

The survey also showed that there were few statistically significant differences across states in the rates of past year MDE among
youths and adults. The survey did not look at reasons for the interstate variances.

MDE, as defined by the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), specifies a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image. [http://www.samhsa.gov/newsroom/advisories/0706114722.aspx](http://www.samhsa.gov/newsroom/advisories/0706114722.aspx)

A report released from the Commonwealth Fund, a private foundation focused on health care, rated states based on 32 indicators, including access, quality, cost, insurance, preventive care, potentially avoidable hospital visits, and premature death (death before age 75). *The Commonwealth Fund Commission on a High-Performance Health System: "Aiming Higher: Results from a State Scorecard on Health System Performance,″ was published on June 13, 2007.* The scorecard is the first of its kind from the Commonwealth Fund, a private foundation focused on health care.

The top five states in order are Hawaii, Iowa, New Hampshire, Vermont, and Maine. These states scored two to three times higher than the lowest-ranked states. The bottom five states are Nevada, Arkansas, Texas, Mississippi, and Oklahoma. According to the report, every state has room for improvement—even those leading the scorecard. Cathy Schoen, co-author and a senior vice president at the fund stated that if all states equaled the top-rated states, there would be 90,000 fewer premature deaths before age 75 from conditions such as diabetes, infection, respiratory disease, and treatable cancers. In addition, 22 million more adults and children would be insured, cutting U.S. uninsured rates in half.

The report supports the results of other studies that indicate no connection exists between states that spend more on health care and quality, as well as those that suggest states with higher spending levels have higher rates of preventable hospitalizations, such as readmissions and admissions for chronic illnesses. The report estimates that Medicare could save $22 billion annually if high-cost states performed as well as the national average.

In addition, the report found racial disparities in preventable deaths nationwide, with an average of 194.1 potentially preventable deaths per 100,000 for blacks and 93.6 per 100,000 for whites. In addition, the report found that half of adults ages 50 and older received recommended preventive care, even in the highest-ranked states. To view the all state rankings, click [here](http://www.samhsa.gov/newsroom/advisories/0706114722.aspx).
• U.S. Medicine Institute published an executive summary from its May roundtable: “Addressing The Consequences Of Obesity In Federal Programs And Policies.” Roundtable participants urged that obesity be recognized as a disease in itself and be eligible for reimbursement. They also recommended research into obesity’s pathophysiologic markers. Obesity rates continue to increase in the United States, even among military personnel who are required to remain fit and trim. Roundtable participants said this sends a message that our society has become “obesogenic” and needs to stop supporting inactivity and high-density, sugary confections in favor of active lifestyles and more healthful foods.

Reserve/Guard

• The total number of Guard and Reserve currently on active duty has increased by 5,545 from the last report to 91,984. The totals for each service are Army National Guard and Army Reserve, 74,155; Navy Reserve, 5,102; Air National Guard and Air Force Reserve, 6,169; Marine Corps Reserve, 6,200; and the Coast Guard Reserve, 358. www.defenselink.mil

Contracts/Procurements

• The Department of Defense, TRICARE Management Activity (TMA) issued a Request For Information (RFI) to solicit feedback from potential offerors, industry representatives, Government agencies, and other interested parties on a draft solicitation for the follow-on acquisition to the three existing TRICARE Managed Care Support (MCS) contracts for the North, South and West Regions. TMA requests and encourages feedback on all areas of the requirement and draft solicitation, particularly input from small businesses and non-incumbents. It is anticipated that the final solicitation will be issued in late summer 2007 following a sources sought notice. All responses will be accepted for approximately 30 calendar days after the posting date.

The Defense Health Program (DHP) consists of direct care provided by DoD personnel through Military Treatment Facilities (MTF) and clinics and purchased care provided through Managed Care Support Contractors. In order to fulfill the purchased care needs of
the DHP, sources/contractors must provide all services necessary to fully support DoD’s primary wartime readiness mission while supplementing the services provided through DoD owned and/or operated health care facilities.

MCS services apply to approximately 9.2 million active and retired members of the Uniformed Services: the U.S. Army, the U.S. Navy, the U.S. Air Force, the U.S. Marine Corps, the U.S. Coast Guard, the Commissioned Corps of the Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric Administration, their spouses and children and their surviving family members subject to the provisions of Chapter 55 of Title 10, U.S.C. Also eligible are Medal of Honor recipients (Chapter 55 of Title 10, U.S.C., Section 1074h).


The US Army Medical Research Acquisition Activity (USAMRAA), on behalf of the TRICARE Management Activity, issued an unrestricted competitive Request for Proposals (RFP) for the requirements of the Reserve Health Readiness Program (RHRP) on June 13, 2007. The RHRP provides health readiness support services to the Service Components (SC), which are composed of the Reserve Components (RC) and Active Components (AC). This requirement provides for the necessary medical and dental standards and requirements essential in maintaining a deployable force. The RHRP succeeds an interagency initiative called the Federal Strategic Health Alliance (FEDS_HEAL) which was created to assist the RCs when increased deployment readiness requirements severely impacted the RCs health readiness. RHRP services include immunizations, physical examinations, Periodic Health Assessments (PHA), Post Deployment Health Re-Assessment (PDHRA), dental examinations and x-rays, dental treatment, laboratory services, occupational health service s, and other services as required to satisfy SC health readiness needs.

AC services will be limited to PDHRA and Individual Medical Readiness for service members in geographically remote areas. The successful Contractor will be required to establish and maintain a nationwide network of health care providers. A single Indefinite Delivery/Indefinite Quantity contract will be awarded to the offeror that provides the Best Value to the Government. The period of performance of the contract will consist of a base period of 12-months and will include four 12-month option periods. Individual task orders will be issued under the contract to provide specific requirements, performance periods, and funding. All responses should be received by July 12, 2007.

http://www.fbo.gov/spg/USA/USAMRAA/DAMD17/W81XWH%2D07%2DR%2D0021/listing.html

Reports/Policies
• The GAO issued “Defense Health Care: Issues Related to Past Drinking Water Contamination at Marine Corps Base Camp Lejeune,” (GAO-07-933T) on June 12, 2007. This testimony summarizes findings from the report about efforts to identify and address the past drinking water contamination; the provision of funding and information from the Department of Defense (DoD) to HHS’s Agency for Toxic Substances and Disease Registry ATSDR; and an assessment of the design of the current ATSDR study. GAO reviewed documents, interviewed officials and former residents, and contracted with the National Academy of Sciences to convene an expert panel to assess the current ATSDR study.

• The GAO issued “Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings,” (GAO-07-231) on May 11, and published it June 12, 2007. In the report, the GAO examined the benefits and premium requirements of Partnership policies as compared with those of traditional long-term care insurance policies; the demographics of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance; and whether the Partnership programs are likely to result in savings for Medicaid.

• The Institute of Medicine (IOM) released “Ethical and Legal Considerations in Mitigating Pandemic Disease: Workshop Summary,” on June 13, 2007. The report lessons learned from past pandemics, identified barriers to equitable and effective responses to future pandemics, and examined opportunities to overcome these obstacles through research, policy, legislation, communication, and community engagement. http://www.iom.edu/CMS/3783/3924/43490.aspx

Legislation

• H.R.2639 (introduced June 11, 2007): To amend the Internal Revenue Code of 1986 to modify the rules with respect to health savings accounts and medical savings accounts, and for other purposes was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
H.R.2646 (introduced June 11, 2007): To amend the Public Health Service Act to establish grant programs to provide funding for mental health services in response to public health emergencies, for statewide plans for providing such services in response to such emergencies, and for the training of mental health professional with respect to the treatment of victims of such emergencies, and to establish the National Mental Health Crisis Response Technical Assistance Center was Referred to the House Committee on Energy and Commerce.
Sponsor: Representative William J. Jefferson [LA-2]

H.R.2647 (introduced June 11, 2007): To amend the Public Health Service Act to improve mental health and substance abuse services for juveniles was referred to the House Committee on Energy and Commerce.
Sponsor: Representative William J. Jefferson. [LA-2]

H.R.2676 (introduced June 12, 2007): To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require group and individual health insurance coverage and group health plans to provide coverage for individuals participating in approved cancer clinical trials was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
Sponsor: Representative Deborah Pryce [OH-15]

H.R.2677 (introduced June 12, 2007): To establish grants to provide health services for improved nutrition, increased physical activity, obesity and eating disorder prevention, and for other purposes was referred to the House Committee on Energy and Commerce.
Sponsor: Representative Mary Bono [CA-45]

H.R.2681 (introduced June 12, 2007): To provide for the maintenance, management, and availability for research of assets of the Air Force Health Study was referred to the Committee on Energy and Commerce, and in addition to the Committee on Veterans'
Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

Sponsor: Representative Corrine Brown [FL-3]

- **H.R.2689** (introduced June 12, 2007): To require the Secretary of Veterans Affairs to establish a program for the provision of readjustment and mental health services to veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom, and for other purposes was referred to the House Committee on Veterans' Affairs.
  Sponsor: Representative Ciro D. Rodriguez [TX-23]

- **H.R.2696** (introduced June 13, 2007): To amend title 38, United States Code, to increase assistance for veterans interred in cemeteries other than national cemeteries, and for other purposes was referred to the House Committee on Veterans' Affairs.
  Sponsor: Representative Doug Lamborn [CO-5]

- **H.R.2697** (introduced June 13, 2007): To amend title 38, United States Code, to expand eligibility for veterans' mortgage life insurance to include members of the Armed Forces receiving specially adapted housing assistance from the Department of Veterans Affairs was referred to the House Committee on Veterans' Affairs.
  Sponsor: Representative Doug Lamborn [CO-5]

- **H.R.2699** (introduced June 13, 2007): To amend title 38, United States Code, to repeal authority for adjustments to per diem payments to homeless veterans service centers for receipt of other sources of income, to extend authorities for certain programs to benefit homeless veterans, and for other purposes was referred to the House Committee on Veterans' Affairs.
  Sponsor: Representative Patrick J. Murphy [PA-8]

- **H.R.2702** (introduced June 13, 2007): To amend title 38, United States Code, to establish a program of educational assistance for members of the Armed Forces who serve in the Armed Forces after September 11, 2001, and for other purposes was referred to the House Committee on Veterans' Affairs.
  Sponsor: Representative Robert C. Scott [VA-3]
• **H.R.2708** (introduced June 13, 2007): To amend the Public Health Service Act and Employee Retirement Income Security Act of 1974 to require that group and individual health insurance coverage and group health plans provide coverage for annual screening mammography for women 40 years of age or older and for such screening and annual magnetic resonance imaging for women at high risk for breast cancer if the coverage or plans include coverage for diagnostic mammography for women 40 years of age or older was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
   Sponsor: Representative Jerrod Nadler [NY-8]

• **S.1588** (introduced June 11, 2007): A bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage for treatment of a minor child's congenital or developmental deformity or disorder due to trauma, infection, tumor, or disease was referred to the Committee on Health, Education, Labor, and Pensions.
   Sponsor: Senator Mary L. Landrieu [LA]

• **S.1604** (introduced June 13, 2007): A bill to increase the number of well-educated nurses and for other purposes was referred to the Committee on Health, Education, Labor, and Pensions.
   Sponsor: Senator Hillary Rodham Clinton [NY]

• **S.1605** (introduced June 13, 2007): A bill to amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes was referred to the Committee on Finance.
   Sponsor: Senator Kent Conrad [ND]

• **S.1606** (introduced June 13, 2007): A bill to provide for the establishment of a comprehensive policy on the care and management of wounded warriors in order to facilitate and enhance their care, rehabilitation, physical evaluation, transition from care by the Department of Defense to care by the Department of Veterans Affairs, and transition from military service to civilian life, and for other purposes was referred to the Committee on Armed Services.
Hill Hearings

• The Veterans Affairs committees for the Senate and House will hold a joint hearing on Sept. 20, 2007, to hear the American Legion's legislative presentation.

• The House Veterans Affairs Committee will hold a hearing on June 20, 2007, to examine Priority 8 Veterans.

• The Senate Veterans Affairs Committee will hold a hearing on June 27, 2007, to examine the nomination of Charles L. Hopkins, of Massachusetts, to be an Assistant Secretary of Veterans Affairs (Operations, Preparedness, Security and Law Enforcement).

• The Senate Veterans Affairs Committee will hold a hearing on July 11, 2007, to examine Veterans Affairs health care funding.

Meetings / Conferences

• The Global Medical Readiness Conference will be held June 25 – 28, 2007, in Orlando, Fl. [https://secure.giuffrida.org/airforce/index.html](https://secure.giuffrida.org/airforce/index.html)

• The Department of Veterans Affairs’ Advisory Committee on OIF/OEF Veterans and Families will hold a town hall meeting on June 27, 2007, in Las Vegas, Nev. [www.va.gov/oifoef](http://www.va.gov/oifoef)
• The Society of Ghana Women’s Medical and Dental Practitioners, the 27th International MWIA Congress is scheduled for July 31 to Aug. 4, 2007 in Accra, Ghana. www.mwiainghana.org


• 46th Annual Research in Medical Education (RIME) Conference will be held Nov. 2-7, 2007, in conjunction with the AAMC Annual Meeting in Washington, D.C.

• The 13th International Congress on Infectious Diseases will be held June 19-22, 2008, in Kuala Lumpur, Malaysia. http://www.isid.org/13th_icid/

If you need further information on any of the items in the Federal Health Update, please contact Kate Connelly Theroux at (703) 447-3257 or by e-mail at kate@usminstitute.org. To subscribe, please visit http://usminstitute.org/subscriber.cfm. To unsubscribe, please send an email to update@usminstitute.org with UNSUBSCRIBE as the subject.